



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  ROBERT D. WILCOX, MD 5316 WEST PLANO PARKWAY PLANO, TX 75093	MFDR Tracking #: M4-09-6509-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY

**The Requestor did not submit a position statement in accordance with rule §133.307.**

**Amount in Dispute:** \$106.11

### PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor provided E&M services to the claimant 9/23/08 then billed Texas Mutual CPT code 99214. Upon receipt of the bill Texas Mutual reviewed the documentation and concluded it did not meet the documentation requirements for that code. Texas Mutual has reviewed the documentation again and sees no reason to change its position. In summary the 9/23/08 document reflects an expanded problem focused History and expanded problem-focused Examination, which is enough to classify the E&M level as 99213. In view of this Texas Mutual cannot reimburse a document that fails to support the documentation requirements of CPT code 99214."

### PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
9/23/08	99214	N/A	\$106.11	\$0.00
			<b>Total Due:</b>	<b>\$0.00</b>

### PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### Background

- 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 11/7/08

- CAC-150 – Payer deems the information submitted does not support this level of service.
- CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group PR or CO depending upon liability).
- 793 – Reduction due to PPO contract. PPO contract was applied by Focus/Aetna workers Comp Access LLC.
- 890 – This level of service is being disputed as it does not meet the components as defined in the "CPT book."

Explanation of benefits dated 2/2/09

- CAC-150 – Payer deems the information submitted does not support this level of service.
- CAC-16 – Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability).
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 793 – Reduction due to PPO contract. PPO contract was applied by Focus/Aetna workers Comp Access LLC.
- 890 – This level of service is being disputed as it does not meet the components as defined in the “CPT book.”

### **Issues**

1. Is there a copy of a contract or any information to support that a contractual agreement exists between the parties to this dispute?
2. Does the submitted documentation support the services billed under CPT code 99214?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. According to the exception codes on the explanation of benefits, the carrier reduced the services in dispute in accordance with Focus/Aetna Workers Comp Access LLC. The amount on the submitted explanation of benefits dated 11/7/08 and 2/2/09 denotes \$0.00. The respondent did not clarify or otherwise address the 45 or 793 claim adjustment codes upon receipt of the request for dispute resolution, nor was documentation provided to support that there is a contract between the provider and the Focus/Aetna Workers Comp Access LLC. For these reasons, the Division finds that the 45 and 793 claim adjustment codes are not supported.
2. The requestor billed CPT code 99214. The description of this code is as follows: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history, a detailed examination and a medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. The documentation the requestor submitted to support the services billed under CPT code 99214 supports an expanded problem focused history, an expanded problem focused examination and a medical decision making of low complexity. Pursuant to rule §134.203(a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare. The documentation does not support the description of CPT code 99214. Therefore, reimbursement to the requestor for CPT code 99214 is not recommended.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is \$0.00.

## **PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

12/16/10

\_\_\_\_\_  
Date

## **PART VII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**